The Training Toole

Client Health and Physical Activity Worksheet

Name: _____

Address: _____

_____

Phone:
Home (___)_____
Business (___)_____
Cell (___)_____
E-mail Address _____

Age: _____ Birthdate: _____
Sex: _____ Height: _____ Weight: _____

Physician's Name: _____
Phone: _____
Address: _____

Emergency Contact-
Name/Relationship: _____
Phone: _____

1. Please check if applicable

	Client		**Family**		**If Yes, Describe**
	YES	NO	YES	NO	
Diabetes	___	___	___	___	_____
High Cholesterol	___	___	___	___	_____
Smoke or use tobacco products	___	___	___	___	_____
Angina/Chest Pain	___	___	___	___	_____
Heart Murmur	___	___	___	___	_____
Irregular Heart Beats	___	___	___	___	_____
Abnormal Electrocardiogram	___	___	___	___	_____
Rheumatic Fever	___	___	___	___	_____
Thrombophlebitis	___	___	___	___	_____
Respiratory Infections	___	___	___	___	_____
Asthma	___	___	___	___	_____
Embolism	___	___	___	___	_____
Aneurysm	___	___	___	___	_____
Stroke	___	___	___	___	_____
Valve Disease	___	___	___	___	_____
Heart Attack	___	___	___	___	_____

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2. Do you have any of the following conditions that may limit your physical activity? (check all that apply)

___Ankle/Foot Injury ___Bone Fracture ___ Arthritis

___Shoulder/Clavicle Injury ___Low Back Pain ___ Tennis Elbow

___ Calcium Deposits ___Wrist/Hand Injury ___Arm/Elbow Injury

___Knee/Thigh Injury ___Hip/Pelvic Injury ___Nerve Damage

___Upper Back Injury ___Head/Neck Injury

___Other If **other**, please explain:_____

_____

3. Has your physician ever advised you against exercise? ___Yes ___No

4. Are you presently receiving physical therapy? ___Yes ___No

5. Are you presently taking any medications? ___Yes ___No

If **yes**, please list names and dosages of each: _____

_____

6. Are you involved in an exercise program at the present time? ___Yes ___No

If **yes**, please describe the program: _____

_____

7. How would you rate the amount of physical activity at work?

___Very Little ___Little ____Moderate ___Active ___Very Active

8. How would you rate the stress level of your job?

___Little ___Moderate ___Stressful

9. When exercising, including climbing stairs, do you ever experience any of the following? (check all that apply)

___Chest Pains ___Shortness of Breath ___Pressure over the Heart

___A Tired-Out Feeling ___Leg Aches ___Dizziness

10. Have you ever had a stress test? ___Yes ___No

If **yes**, date of most recent test: _____

Results: ___Normal ___Abnormal

11. What was your weight one year ago? _____

Five years ago? _____ At age: _____

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12. Do you follow any special diet at the present time? ___Yes ___No

If so, what type?

___Low Cholesterol/Low Fat ___Low Salt ___Reduced Calorie
___Liquid Diet ___Other
If **other**, please explain: _____

_____

13. What are your personal exercise program goals?

___Weight Control/Loss ___Staying in Shape ____Stress Reduction
___Increasing Strength ___Cardiovascular Conditioning
___Other

If **other**, please specify:

_____
_____

14. Are there any other comments or concerns you have?

_____

_____

_____

_____

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